

STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION By _____AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO: Any and all treating physicians or facilities

5:04cv165RAH/wcs

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L.B.S.
Patient Signature11/22/81
D.O.B.589-10 3150
Social Sec No.7/14/04
Date

Authorized person other than patient.

Relationship

STATE OF FLORIDA
COUNTY OF BRADFORDBefore me, personally appeared Ramon A. Burroto Jr.Whose identity is known to me by S/SN 51
(Type of identification) and who, acknowledges that his/her signature appears above.Sworn to or affirmed by Affiant before me this 14 day of July, 2004Robert D. Underhill

NOTARY PUBLIC State of Florida

JULY 24 2006

My Commission Expires

Robert D. Underhill

Name (please print)

Witness Signature (if not notarized)



Robert D. Underhill
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